
Indiana
Medicaid
Program
FY 2000 Annual Report

Indiana Medicaid Program

SFY 2000 Annual Report

July 1, 1999–June 30, 2000

The Honorable Frank O'Bannon
Governor of the State of Indiana
Indiana State House
Indianapolis, Indiana 46204

Dear Governor O'Bannon:

It is my pleasure to present to you an annual report of the Indiana Medicaid Program administered by the Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP). This report highlights the accomplishments and significant activities of OMPP for the 2000 state fiscal year (July 1, 1999 through June 30, 2000) and presents general information on the Indiana Medicaid Program.

In SFY 2000, Hoosier Healthwise enrollment continued to increase overall as a result of a simplified application process, the establishment of over 500 community enrollment centers, and a marketing campaign that concluded in June 2000. The total number of Hoosier Healthwise members increased to 376,000 by the end of SFY 2000. This was a 14 percent increase in enrollment from SFY 1999. Additionally, 60 more doctors enrolled to be Primary Medical Providers (PMP) in the program bringing the total number of participating PMPs to over 2,000.

The Indiana Long Term Care Insurance Program experienced a large increase in the sale of "Partnership Policies." The total number of policies purchased doubled from calendar year 1999 to calendar year 2000 resulting in a total of nearly 12,000 Partnership policies sold. SFY 2000 also saw the implementation of legislation granting Partnership policyholders a state tax deduction in the amount of 100% of premium paid.

Indiana was also granted approval to institute the Home and Community-Based Services Waiver for Person with Traumatic Brain Injury in SFY 2000. This waiver was authorized by the Health Care Financing Administration (HCFA) to serve up to 200 persons with traumatic brain injury who would otherwise require the level of services of a nursing facility.

Finally, OMPP continued to work throughout SFY 2000 to improve claims processing performance, to increase collections from Medicare and other third party payers, and to enhance efforts to monitor the appropriateness of payments in the Medicaid program.

On behalf of the entire OMPP staff, I want to thank you for your support of this important program, which provides vital health care services to so many Indiana citizens. In addition, I would like to thank the former Assistant Secretary, Kathleen Gifford, for her leadership and dedication to one of Indiana's most important programs.

Sincerely,

Melanie Bella
Assistant Secretary
Office of Medicaid Policy and Planning

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SFY 2000 Highlights

Expansion of Hoosier Healthwise

In 1999, Governor O'Bannon signed into law "Phase II" of the federal Children's Health Insurance Program (CHIP), which began January 1, 2000. The second phase of CHIP, called Hoosier Healthwise Package C - Children's Health Plan, is a non-Medicaid expansion of Hoosier Healthwise and focuses on children in families with income levels between 150 and 200 percent of the federal poverty level. By June 30, 2000, approximately 3,300 children enrolled in Package C, bringing the total CHIP enrollment (Phase I and II) up to 34,000 children.

In addition to increased enrollment as a result of the CHIP expansion, Hoosier Healthwise enrollment continued to increase overall as a result of a simplified application process, the establishment of over 500 community enrollment centers, and the marketing campaign that concluded in June 2000. The table below lists the total enrollment of children, pregnant women, and low-income families in the Hoosier Healthwise managed care program at the end of SFY 1999 and at the end of SFY 2000. The total number of members increased almost 14 percent during SFY 2000. The Hoosier Healthwise program also continued to enroll more doctors to be Primary Medical Providers (PMPs). Sixty additional PMPs were enrolled in the Hoosier Healthwise program throughout the State of Indiana in SFY 2000.

Enrollment Changes in Hoosier Healthwise-SFY 2000 [Table 1]

	July 1999	June 2000	% change
Total Members Enrolled	331,207	376,066	14%
Total PMPs Enrolled	1,941	2,001	3%

Continued Improvements in Access to Dental Services

OMPP continues to report on the impact of the rate increases for dental services made in 1998. In addition, dental services were carved out of Risk Based Managed Care (RBMC). (See discussion of Hoosier Healthwise Managed Care Program for an explanation of terms). As a result, all dental claims are paid to dentists directly on a fee-for-service basis and Hoosier Healthwise Managed Care members have direct access to dental services. OMPP was assisted in these policy changes through recommendations made by the Dental Advisory Panel, composed of practicing dental providers from throughout the state, and the Indiana Dental Association.

The outcome of these efforts continues to be positive. From May 1998 to June 2000, the number of dental providers enrolled in the Medicaid program increased 30 percent, bringing the total enrolled in June 2000 to 1,750 providers. As the number of providers has increased so have the number of Medicaid members receiving dental services. One-third of all Medicaid members, or 192,000 recipients, received dental services in SFY 2000. This was a 32 percent increase from SFY 1999. In SFY 2000, there were 30 percent more dental recipients than there were in SFY 1999. Of those recipients, 65 percent are children under age 19, with a total of 124,000 children receiving dental services.

Expansion of the Medicaid Disability Program

In SFY 2000 Governor O'Bannon signed into law a new Medicaid disability definition that allowed the State to expand the Medicaid program and extend benefits to more disabled persons in Indiana. Effective January 1, 2001, the disability definition now makes Medicaid health care benefits available to individuals who have severe medical conditions, lasting four years or more, prohibiting them from working. The Indiana Medicaid Program is expected to provide benefits to an additional 5,500 Hoosiers needing medical assistance, due to this expansion of the disability definition.

Indiana Long Term Care Insurance Program - Policy Sales Double!

The Indiana Long Term Care Insurance Program, also known as the Indiana "Partnership Program," is an innovative public/private partnership between the Indiana Medicaid Program, the Indiana Department of Insurance and private long term care insurance companies, designed to help Indiana residents finance their potential long term care without fear of impoverishment. The Program, administered by OMPP, encourages the sale and purchase of private long-term care insurance by providing "Medicaid asset protection" to purchasers of qualifying policies. The Program began operation on May 17, 1993, with state approval of the first eight participating insurers. (There are 15 participating insurers as of June 2000). Indiana is one of only four states (along with California, Connecticut and New York) with such a program.

Since 1993 when policies were first available, 11,480 Partnership policies have been purchased (through June 2000). 60 percent of the purchasers have been female and 74 percent have been married. The average age of the individual at the time of purchase was sixty-five.

The total number of policies purchased doubled from calendar year 1999 to calendar year 2000. Of the approximate 12,000 policies purchased, 75 percent include coverage for nursing home and home care. Fifty policyholders have received policy benefits since the inception of the Partnership Program. Of these fifty, fourteen were receiving policy benefits as of June 2000, nine have died, and six have exhausted their policy benefits. Of the six who have exhausted their benefits, four are receiving Medicaid assistance after receiving their asset disregard (for using their Partnership policy first). Two policyholders who exhausted their benefits are not eligible for Medicaid assistance currently, due to the amount of assets they own being greater than the amount of asset protection they earned under their Partnership policies.

Other accomplishments during SFY 2000 include the implementation of legislation granting Partnership policyholders a state tax deduction in the amount of 100% of premium paid; 24,303 hits to the Program's website; and Program staff conducting 109 presentations reaching over 2,500 consumers and professionals.

Home and Community-Based Services Waivers

Traumatic Brain Injury Waiver

Pursuant to Senate Enrolled Act 125, Indiana initiated the Home and Community-Based Services Waiver for Persons with Traumatic Brain Injury effective January 1, 2000. This waiver is authorized by HCFA for a three-year period, to serve up to 200 persons with traumatic brain injury who would otherwise require the level of services of a nursing facility.

ICF/MR Waiver

In June 2000, OMPP received HCFA's report of the management review conducted on Indiana's Home and Community-Based Services Waiver for Persons with Mental Retardation and Developmental Disabilities. This report included findings from an on-site review that was conducted in Indiana in December 1999. The HCFA review team identified examples of good practices that Indiana could build on to improve its waiver program. However, overall, HCFA concluded that Indiana had not assured the health and welfare of its waiver consumers and several significant problems were specifically identified. Since receipt of that report, OMPP and the Division of Disability Aging and Rehabilitative Services (DDARS) that manages the waivers on a daily basis, have worked closely with HCFA to resolve the outstanding issues to ensure the health and welfare of waiver recipients. The final outcome was that Indiana would develop an entirely new Medicaid waiver program for persons with developmental disabilities to replace the existing waiver program.

Waiver Services as Alternatives to Nursing Facility Placement

House Enrolled Act 1197 was passed in SFY 2000 authorizing FSSA to develop and submit to HCFA before October 1, 2000, a proposal for a Medicaid Waiver for Adult Foster Care and Assisted Living. HEA 1197 also included an expansion of the existing adult day care services in the Aged and Disabled Waiver. A Long-Term Care Task Force was appointed by Governor O'Bannon to oversee the successful implementation of a Medicaid Assisted Living and Adult Foster Care Waiver, as well as the expansion of the adult day care services. On June 15, 2000, the first of three comprehensive reports from the Long-Term Care Task Force was provided to the Governor on recommendations for the waiver initiatives.

ICF/MR Institutional Program

Following the Medicaid decertification of Muscatatuck State Developmental Center (MSDC), in April 1999, FSSA worked closely with the Indiana State Department of Health to regain certification. During this time period, DDARS also actively worked to downsize the number of residents at MSDC, by placing eligible individuals on the existing ICF/MR home and community-based services waiver and in other institutional settings. The recertification of MSDC started with the first of four phases being recertified March 23, 2000. The second phase was recertified May 26, 2000.

Visit our website at www.IN.gov/fssa/iltcp.

Overview of the Indiana Medicaid Program

Medicaid is a health care program for low-income individuals that is jointly financed by the state and federal governments. Each state administers its own program within broad federal guidelines. Thus, state programs vary in eligibility criteria, services covered, limitations on services and reimbursement levels. In Indiana, Medicaid is administered by the Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP). During State Fiscal Year 2000, the federal financial share of Indiana's Medicaid program was approximately 61.7 percent, while the state's share was about 38.3 percent.

Who is Covered by Indiana Medicaid?

Medicaid was created to provide health care to certain low-income individuals. State Medicaid programs are required by the federal government to cover certain groups of low-income individuals, while other individuals are covered at the state's discretion. To be eligible for Medicaid, a person must belong to one of the categories described below and meet specific financial criteria. The Medicaid Eligibility Overview Table on page 7 lists the specific criteria for each eligibility category that a person must meet in order to become eligible for Indiana Medicaid.

Members of Low-Income Families with Children. Families meeting the income and resource standards for the federal Temporary Assistance to Needy Families (TANF) program are also eligible for Medicaid whether or not they actually receive TANF cash assistance.

Pregnant Women and Children Under Age 19. Pregnant women and children under age 19 with family incomes up to 150 percent of the federal poverty level are eligible for Medicaid. Prior to July 1, 1998, children age one through five were not eligible if their family incomes exceeded 133 percent of the federal poverty level and children age 6 through 18 were not eligible if their family incomes exceeded 100 percent of the federal poverty level. As of September 1, 1998, all Medicaid eligible children are entitled to twelve months of continuous Medicaid coverage regardless of subsequent changes in family income. The income standard and continuous coverage changes were enacted in 1998 as "Phase I" of Indiana's implementation of the federal Children's Health Insurance Program (CHIP). In 1999, Governor O'Bannon signed into law the second phase of CHIP, which began January 1, 2000. The second phase of CHIP, called Hoosier Healthwise Package C - Children's Health Plan, is a non-Medicaid expansion of Indiana's Hoosier Healthwise managed care program. The Phase II expansion of CHIP focuses on children in families with income levels between 150 and 200 percent of the federal poverty level.

Aged. Individuals age 65 or older are eligible for Medicaid if they meet the financial criteria described in the Medicaid Eligibility Overview Table on page 7. The financial criteria are more lenient if one spouse is in a nursing facility, while the other lives in the community. Persons eligible for Medicare Part A may qualify to have Medicaid pay their Medicare premiums, co-insurance and deductibles as a Qualified Medicare Beneficiary (QMB). In addition, a person categorized as a Specified Low-Income Medicare Beneficiary (SLMB) or a Qualifying Individual-1 (QI-1) due to Medicare part A eligibility and income requirements may qualify to have Medicaid pay their Medicare part B premiums. Medicaid will also pay a small portion of Medicare Part B premiums for Qualified Individuals-2 (QI-2) and the Medicare Part A premiums for Qualified Disabled and Working Individuals.

Blind and Disabled. For eligibility purposes, the definition of a blind individual is the same definition as that used by the federal Social Security Administration (SSA). The SSA definition states that an eligible person has vision 20/200 or less in the better eye with the use of

Medicaid Eligibility Overview [Table 2]

Category	Non-financial Criteria	Typical Family Unit	Monthly Income Limit for Typical Family Unit	Resource Limit	Coverage Type	Eligibility Period
Low Income Families	Dependent Child in home	1 Adult, 1 Child	$229 (25% of FPL)	$1,000	Full	6 month review
Pregnant Women	Pregnant	1 Unborn Child, 1 Adult	$229 (25% of FPL)	$1,000	Full	Terminates 60 days after delivery
	Pregnant	1 Unborn Child, 2 Adults, 1 Child	$2,132 (150% of FPL)	No Limit	LImited to pregnancy related services	Terminates 60 days after delivery
Newborn Children	Newborn Child of a female Medicaid recipient	2 Adults, 2 Children	No Limit	No Limit	Full	Until Child turns age 1
Under age 19	Child under age 19	2 Adults, 2 Children	$2,132 (150% FPL)[1]	No limit	Full	Continuous for 12 months
Aged[2]	Age 65 or older	Married Couple, Individual	Couple $769, Individual $512 (Same as SSI Standards)	Couple $2,250 Individual $1,500	Full	Annual Review
Blind	Blind	Married Couple, Individual	Couple $769, Individual $512 (Same as SSI Standards)	Couple $2,250 Individual $1,500	Full	Annual Review
Disabled	Substantial & indefinite impairment	Married Couple, Individual	Couple $769, Individual $512 (Same as SSI Standards)	Couple $2,250 Individual $1,500	Full	Annual Review
Medicare Catastrophic Coverage Act of 1988 (MCCA)	One spouse in nursing facility, one spouse in the community	Married Couple	$1,407 plus a % of shelter expenses not to exceed $2,103 for spouse at home.	$16,824-$84,120	Full	Annual Review
Qualified Medicare Beneficiary (QMB)[3]	Eligible for Medicare Part A	Married Couple, Individual	Couple $938, Individual $696 (100% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare premiums, deductibles, co-insurance	Annual Review
Specified Low Income Medicare Beneficiary[3]	Eligible for Medicare Part A	Married Couple, Individual	Couple $1,125, Individual $835 (120% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare Part B premium	Annual Review
Qualified Individual-1[3]	Eligible for Medicare Part A	Married Couple, Individual	Couple $1,266, Individual $940 (135% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare Part B premium	Annual Review[4]
Qualified Individual-2[3]	Eligible for Medicare Part A	Married Couple, Individual	Couple $1,641, Individual $1,218 (175% of FPL)	Couple $6,000 Individual $4,000	$2.87 monthly, paid end of year	Annual Review[4]
Qualified Disabled Worker	Lost Medicare Part A due to Earnings	Married Couple, Individual	Couple $1,875, Individual $1,392 (200% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare Part A premium	Annual Review

[1] Effective July 1, 1998, children age 1-5, inclusive, with income between 133% and 150% of the poverty level and children age 6-18, inclusive, with income between 100% and 150% of the poverty level became eligible. This expansion was "Phase 1" of Indiana's Children Health Insurance Program (CHIP). Children under age 19 in all categories receive 12 months of continuous eligibilty without regard to changes in income or other circumstances. Effective January 1, 2000, "Phase Two" of CHIP expanded to include children between 150% and 200% of the poverty level.

[2] Income Levels January 2000 - December 2000. All income standards (except those for Low Income Families and Pregnant Women – full coverage) and the MCCA resource limits are increased annually.

[3] Income Levels April 2000 - March 2001. All income standards (except those for Low Income Families and Pregnant Women – full coverage) and the MCCA resource limits are increased annually.

[4] Applications are approved on a first come, first served basis, until federal allotment is expended.

correcting lenses, or with tunnel vision of 20 degrees or less, or who met the October 1972 State definition of blindness and received payments under the State's program of Aid to the Blind (AB) in December 1973, or persons aged 65 or older who receive Supplemental Security Income (SSI) because they are blind and are classified as blind rather than aged.

Currently, to be eligible in the disability category, a person must have a physical or mental impairment, disease or loss that appears reasonably certain to continue throughout the lifetime of the individual without significant improvement and that does or will substantially impair the individual's ability to perform labor or to engage in a useful occupation. Effective January 1, 2001, the disability definition was expanded to allow health care benefits to be available to individuals who have severe medical conditions that are expected to last for four years or more and that will prohibit the individuals from working. Blind and disabled recipients may also be eligible for the Medicare-related programs described above, if they are eligible for Medicare.

It is important to note that Indiana has the most restrictive disability eligibility standard in the country. It is one of only two states that follow a more restrictive medical eligibility definition than is required by the federal Social Security Administration (SSA), which determines eligibility for the Supplemental Security Income (SSI) and the Retirement, Survivors, and Disability Insurance (RSDI) program. Furthermore, Indiana is one of only twelve states that has financial criteria that are more restrictive than those used by the SSA.

What Services are Covered Under Indiana Medicaid?

State Medicaid programs are required to provide certain basic services to beneficiaries in order to qualify for federal matching funds. In addition to qualifying for federal matching funds through the provision of certain basic services, states may also receive matching funds for a variety of optional services approved by the federal government. In State Fiscal Year (SFY) 2000, Indiana provided 31 of 34 possible optional services, making the Indiana Medicaid program one of the most comprehensive in the country.

Mandatory Services:

- Early/periodic screening diagnosis & treatment for those under age 21
- Family planning services and supplies
- Inpatient hospital services
- Laboratory and x-ray services
- Nurse midwife services
- Nurse practitioners' services
- Nursing facility and home health services for those age 21 and over
- Outpatient hospital services
- Physicians services and medical & surgical services of a dentist
- Rural health clinic and federally qualified health center services

Optional services provided by Indiana Medicaid:

- Case management services
- Chiropractic services
- Christian Science nurses
- Christian Science sanitariums
- Clinical services
- Dental services, including dentures and partials for adults
- Diagnosis services
- Emergency hospital services
- Eyeglasses
- Hospice care
- Inpatient hospital services for those above age 65 in institutions for mental diseases
- Inpatient psychiatric services for those under age 21
- Intermediate care for the mentally retarded
- Medical social worker services
- Nurse anesthetists services
- Nursing facility services for those under age 21
- Occupational therapy
- Optometry services
- Physical therapy
- Podiatry services
- Prescribed drugs
- Preventive services
- Private duty nursing services
- Prosthetic devices
- Psychological services
- Rehabilitative services
- Respiratory care services
- Screening services
- Smoking Cessation
- Speech, hearing, and language disorders
- Transportation services

What is the Cost of the Medicaid Program to Indiana?

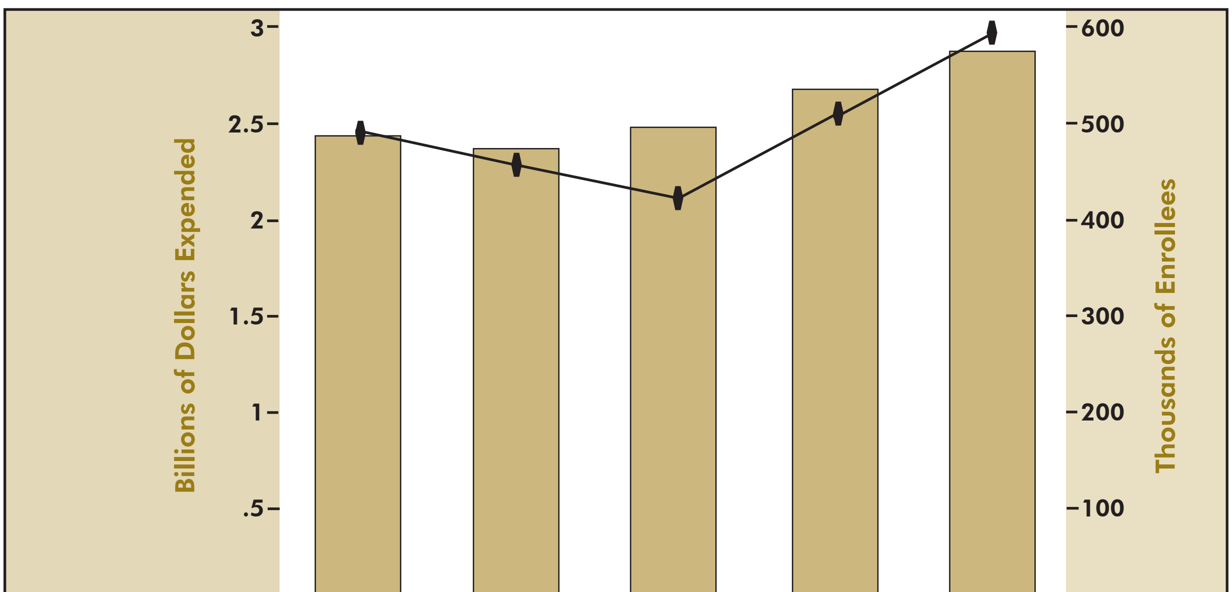
Medicaid Services. Medicaid is a major budgetary commitment for the State of Indiana, consuming approximately 13 percent of the state general fund budget in SFY 2000. In an effort to control rapidly escalating costs for services that more than doubled from SFY 1989 ($1.13 billion) to SFY 1993 ($2.32 billion), numerous cost containment initiatives were implemented beginning in SFY 1993. Those initiatives, combined with enrollment decreases resulting from welfare reform efforts, substantially reduced the growth in Medicaid services expenditures from SFY 1994 through SFY 1998. However, from SFY 1999 to SFY 2000 expenditures rose 10 percent while enrollment grew 13 percent largely due to the Medicaid expansion of healthcare services to children in the CHIP Phase I and Phase II expansions that occurred between 1998 and 2000.

Due to these rising costs, OMPP is now exploring options to reemphasize cost containment strategies in the upcoming years.

The Table found on page10 lists the number of recipients[5] and amount of expenditures by the Medicaid categories of service. Of the $2.92 billion Indiana Medicaid spent for services in SFY 2000:

- Acute care services accounted for about 65.8 percent, including capitation payments to managed care organizations.
- Long-term care services accounted for 41.1 percent[6] of expenditures. (Medicaid pays for approximately 62 percent of all nursing home residents in Indiana.)
- The federal and state share was $1.81 billion and $1.11 billion, respectively.

Medicaid Enrollees and Expenditures[7,8,9] [Figure 1]



	1996	1997	1998	1999	2000
Enrollees	483	455	445	519	575
Expenditures	$2.403 Billion	$2.332 Billion	$2.395 Billion	$2.660 Billion	$2.924 Billion

[5] *"Recipient" refers to an enrollee for whom one or more Medicaid claims have been paid in a given year.*

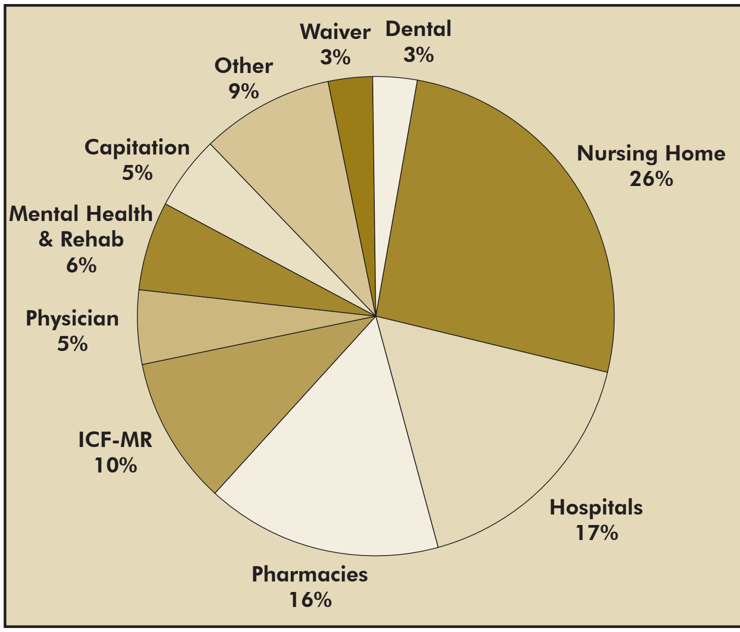
[6] *Long-term care services include total institutional care, total community based waiver, home health and hospice.*

[7] *Due to the implementation of a new Data Management and Analysis System in the fall of 1996, historical SFY figures previously published have been modified for consistency in reporting.*

[8] *Due to the implementation of the Indiana*AIM *claims processing system in February 1995, SFY 1996 expenditures are overstated.*

[9] *Expenditures exclude DSH payments.*

Medicaid Expenditures by Provider Category [Figure 2]



Provider Category	Expenditures (in Millions)
Nursing Home	$ 773
Hospitals	498
Pharmacies	454
ICF-MR	289
Physician	156
Mental Health & Rehab	164
Capitation	145
Waiver	101
Dental	88
Other	256
Total	**$2,924**

Expenditures and Recipients by Category of Service (expenditures are in dollars)[10,11] [Table 3]

Medicaid Category of Service	Unduplicated Recipients	SFY 2000 Expenditures
Inpatient Services	99,380	382,818,104
Inpatient Psychiatric State	517	11,561,618
Inpatient Psychiatric Private	4,728	21,608,685
Outpatient Emergency	83,652	11,275,614
Outpatient Non-Emergency	100,658	8,158,618
Outpatient Non-Emergency Room	243,316	96,111,953
Capitated Services-Risk Based Premiums	172,863	145,352,646
Other Services	291,607	64,016,525
Physician PCCM Administrative Fee	1,002	8,556,662
Physician General Practitioner	42,275	5,443,925
Physician Family Practitioner	153,888	22,134,746
Physician General Pediatrics	77,327	13,981,299
Physician OB/GYN	42,348	16,028,594
Physician General Internist	52,705	8,695,868
Physician Specialist	241,855	59,659,590
Non-Physician Practitioner	43,749	8,438,806
Physician Ambulatory Surgery Center	1,616	287,313
Physician Medical Clinic	106,924	21,456,414
Legend Drugs	405,188	433,362,866
OTC Drugs	136,419	20,557,208
DME Supplies	81,321	52,901,423
Transportation Services	74,601	25,617,836
Nursing Home Services	46,200	772,959,757
ICF-MR Small Group	4,174	199,873,553
ICF-MR Larger Private	1,062	36,995,193
ICF-MR State	523	52,350,946
Home Health Services/Other	10,814	47,477,204
Mental Health Rehab Services	38,142	132,343,241
Other Mental Health Services	72,304	31,216,602
Dental Services	192,222	88,220,008
Chiropractic Services	7,860	2,102,034
Podiatrist Services	21,535	1,473,146
Optometric & Optician Services	108,534	12,728,741
Waiver Services	5,089	101,072,801
Hospice Services	1,686	7,400,673
Total	651,924	$2,924,240,212

[10]*"Recipient" refers to an enrollee for whom one or more Medicaid claims have been paid in a given year. A "recipient" also includes an enrollee for whom Indiana has paid a monthly capitation payment, even if that enrollee does not receive a medical service.*

[11]*Categories of Service are as defined by Electronic Data Systems (EDS). Expenditures include State and Federal share. Source: DataProbe (2000)-includes line items for PCCM Physician Administration Fee and RBMC Capitation Payments.*

Disproportionate Share Hospital Payments. When determining payments for inpatient hospital care, federal law requires state Medicaid programs to provide special consideration for hospitals that serve a disproportionate number of low-income patients. This requirement is referred to as the Medicaid disproportionate share hospital (DSH) payment adjustment. Indiana law provides for municipal, private psychiatric, state mental health, acute, and community mental health center (CMHC) DSH payments. The difference between these types of DSH payments is the funding source of the non-federal share. For private psychiatric DSH and a portion of the acute DSH, the non-federal share is appropriated from state general funds for payments to acute care and private psychiatric hospitals, and from the state mental health fund for payments to state psychiatric hospitals. The non-federal share for municipal, CMHC, and remaining acute DSH is provided through intergovernmental transfers from the Marion County Health and Hospital Corporation, Indiana University, municipal hospitals and CMHCs.

SFY 2000 DSH Payments [Table 4]

Basic DSH	
Small Acute	$8,000,000
Private Psychiatric	$1,588,400
State Psychiatric	$105,416,944
Enhanced DSH	$352,551,771
Total	**$467,557,115**

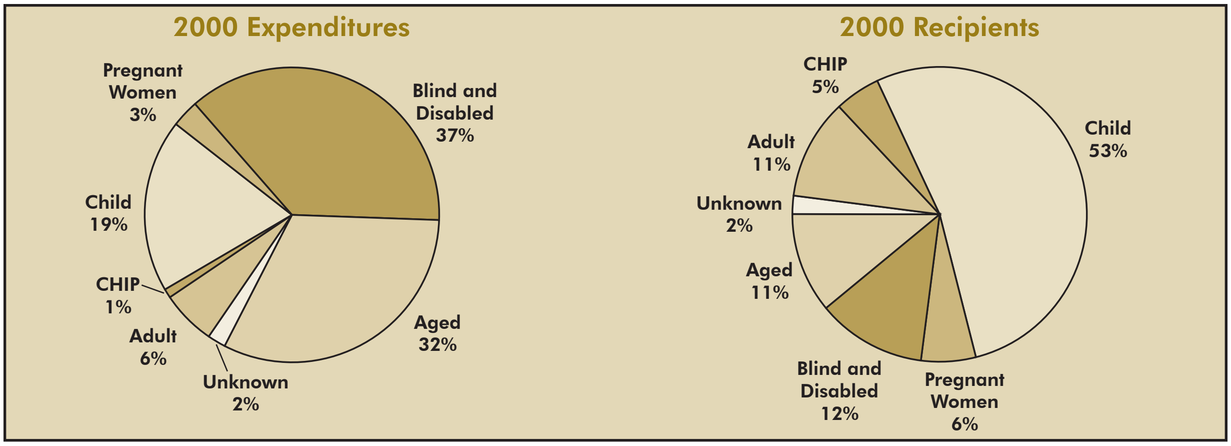
Medicaid Administration. In addition to expenditures of $2.92 billion for health care services and $467.6 million for DSH payments, $100.6 million was expended in SFY 2000 to administer the Indiana Medicaid program. Thus, 97 cents of every Medicaid dollar was used to fund direct health care services in SFY 2000.

Who is Utilizing Medicaid Services?

During SFY 2000, there were a total of 651,924 Medicaid recipients. "Recipient" refers to an enrollee for whom one or more Medicaid claims have been paid in a given year. A "recipient" also includes an enrollee for whom Indiana Medicaid has paid a monthly capitation payment, even if that enrollee did not receive a medical service.

Although adults and children in low-income families make up approximately 73 percent of Medicaid recipients, they account for only 26 percent of Medicaid spending. The aged, blind and disabled account for a majority of spending (69 percent), but only comprise for 25 percent of the recipients.

[Figure 3]



Recipient Trends

(Thousands)	SFY 1996	SFY 1997	SFY 1998	SFY 1999	SFY 2000
Adult	91	72	63	66	70
Aged	73	73	71	72	71
CHIP[12]	0	0	0	22	34
Child	329	295	304	315	348
Blind and Disabled	75	76	77	83	79
Pregnant Women	45	45	48	45	37
Unknown	6	15	20	7	14
Total	**619**	**576**	**584**	**609**	**652**

Expenditure Trends[13]

(Millions of Dollars)	SFY 1996	SFY 1997	SFY 1998	SFY 1999	SFY 2000
Adult	157	127	106	130	174
Aged	804	790	805	891	923
CHIP[12]	-	-	-	16	24
Child	379	352	380	463	549
Blind and Disabled	919	925	970	1,032	1,110
Pregnant Women	98	88	85	80	82
Unknown	46	50	49	48	62
Total	**$2,403**	**$2,332**	**$2,395**	**$2,660**	**$2,924**

Dollars per Recipient

	SFY 1996	SFY 1997	SFY 1998	SFY 1999	SFY 2000
Adult	91	72	63	66	70
Aged	73	73	71	72	71
CHIP[12]	0	0	0	22	34
Child	329	295	304	315	348
Blind and Disabled	75	76	77	83	79
Pregnant Women	45	45	48	45	37
Unknown	6	15	20	7	14
Total	**619**	**576**	**584**	**609**	**652**

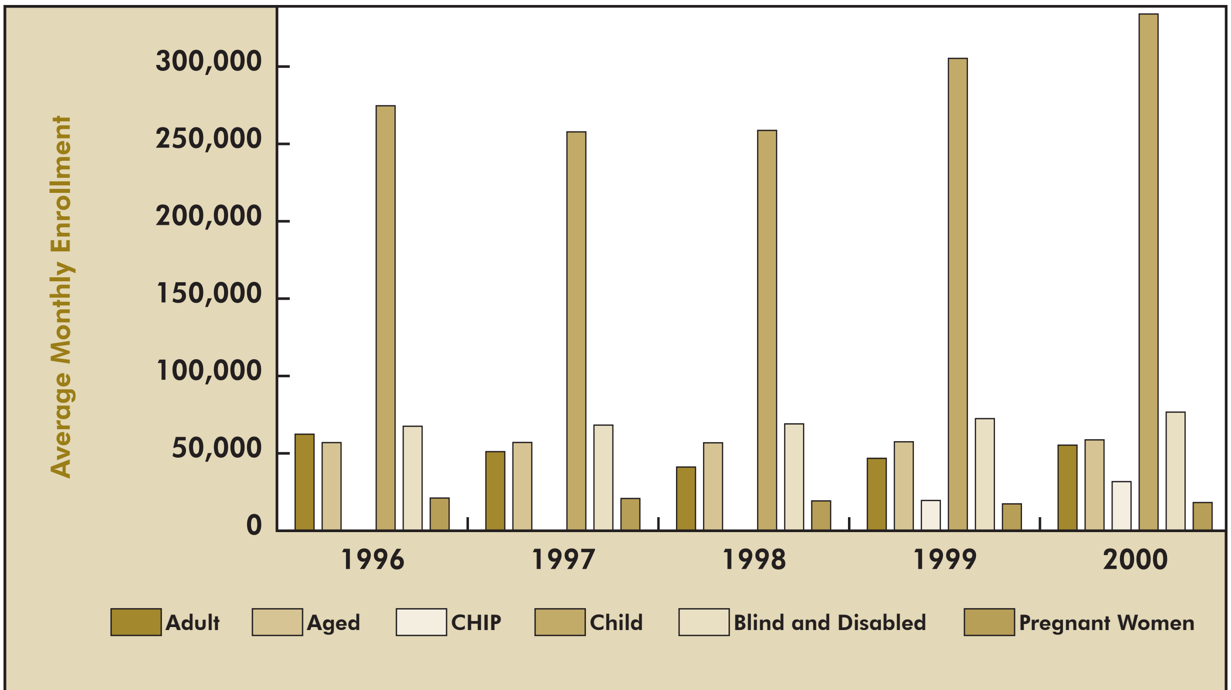
[12] *The CHIP category for SFY 1999 includes only the expenditures and recipients for children who became eligible for Medicaid as a result of the July 1, 1998 expansion. These data do not include children born before October 1, 1983 who receive the enhance matched rate from the Federal program. The CHIP category for 2000 does not include CHIP II-Package C recipients.*

[13] *Expenditures exclude DSH payments.*

How has Medicaid Enrollment Changed?

The average monthly Medicaid enrollment during SFY 2000 was 574,970 members. The monthly average is a more useful measure of Medicaid coverage because it takes into consideration the length of time that members remain eligible. As the Medicaid Enrollees by Aid Group Table below indicates, in the mid 1990s, the number of TANF adults, low-income pregnant women, and children enrollees decreased due to Indiana's welfare reform efforts and favorable economic conditions. In the late 1990s, the trend reversed through aggressive outreach and passage of the 1998 (Phase I) and 1999 (Phase II) CHIP legislation. As of June 2000, 128,386 additional children were enrolled in Indiana Medicaid to receive health care through the Hoosier Healthwise managed care program. This is a 41 percent net increase in age 0-18 enrollment from SFY 1998 to SFY 2000. The Hoosier Healthwise outreach also caused the parents of these children to enroll in Medicaid resulting in a 34 percent increase in Adult enrollment between SFY 1998 and SFY 2000. The average monthly enrollment in the aged, blind and disabled categories, which have the highest per recipient cost, have also increased steadily since SFY 1998.

Medicaid Enrollees by Aid Category [Figure 4]



Aid Group	1996	1997	1998	1999	2000
Adult	62,447	51,163	41,213	46,865	55,367
Aged	57,011	57,104	56,892	57,537	58,780
CHIP I	-	-	2	19,603	31,790
Child	274,722	257,851	258,804	305,350	334,047
Blind and Disabled	67,192	68,319	69,111	72,511	76,715
Pregnant Women	21,176	20,855	19,333	17,415	18,271
Total	482,548	455,322	445,355	519,281	574,970

Figures are not consistent with average monthly enrollment numbers previously reported. Average monthly enrollment includes retroactive eligibility, therefore altering the number previously reported.

Medicaid Recipients as a Percent of Total State Population

Federal Fiscal Year 1998[14] [Table 5]

1.	Tennessee	33.95
2.	District of Columbia	31.76
3.	Washington	24.84
4.	California	21.68
5.	Vermont	20.98
6.	New Mexico	18.97
7.	West Virginia	18.92
8.	Mississippi	17.65
9.	New York	16.91
10.	Arkansas	16.73
11.	Louisiana	16.49
12.	Kentucky	16.37
13.	Georgia	15.99
14.	Oregon	15.58
15.	South Carolina	15.51
16.	Rhode Island	15.49
17.	North Carolina	15.48
18.	Hawaii	15.47
19.	Massachusetts	14.77
20.	Michigan	13.88
21.	Maine	13.70
22.	Delaware	13.64
23.	Missouri	13.50
24.	Florida	12.77
25.	Nebraska	12.70
26.	Pennsylvania	12.69
27.	Alaska	12.13
28.	South Dakota	12.13
29.	Alabama	12.11
30.	Texas	11.77
31.	Connecticut	11.64
32.	Ohio	11.52
33.	Montana	11.44
34.	Minnesota	11.39
35.	Illinois	11.32
36.	Iowa	11.00
37.	Maryland	10.93
38.	Arizona	10.87
39.	Indiana	10.29
40.	Utah	10.28
41.	Oklahoma	10.23
42.	Idaho	10.03
43.	New Jersey	10.02
44.	Wisconsin	9.93
45.	North Dakota	9.76
46.	Virginia	9.62
47.	Wyoming	9.59
48.	Kansas	9.20
49.	Colorado	8.69
50.	New Hampshire	7.93
51.	Nevada	7.34
U.S. AVERAGE		**15.04%**

Total Medicaid Per Capita Expenditures

Federal Fiscal Year 1998[14] (Amounts shown are dollars) [Table 6]

1.	District of Columbia	1,397.93
2.	New York	1,336.90
3.	Rhode Island	930.07
4.	Massachusetts	749.84
5.	Connecticut	739.38
6.	West Virginia	686.39
7.	Minnesota	618.88
8.	Kentucky	616.10
9.	Maine	600.38
10.	Vermont	594.60
11.	Tennessee	583.21
12.	Delaware	564.46
13.	Ohio	546.05
14.	Louisiana	545.55
15.	Arkansas	542.01
16.	Alaska	538.07
17.	North Dakota	534.30
18.	North Carolina	531.90
19.	South Carolina	526.24
20.	Mississippi	524.10
21.	New Jersey	519.88
22.	Illinois	512.47
23.	New Hampshire	511.38
24.	Pennsylvania	506.62
25.	New Mexico	496.36
26.	Maryland	484.79
27.	South Dakota	482.05
28.	Missouri	472.49
29.	Nebraska	452.97
30.	Iowa	450.23
31.	Michigan	442.59
32.	Alabama	437.11
33.	California	435.82
34.	Indiana	434.64
35.	Hawaii	425.34
36.	Wisconsin	422.40
37.	Oregon	419.72
38.	Montana	410.29
39.	Wyoming	399.26
40.	Georgia	394.17
41.	Florida	381.26
42.	Colorado	362.47
43.	Texas	361.34
44.	Washington	359.31
45.	Arizona	352.13
46.	Oklahoma	351.94
47.	Kansas	348.54
48.	Idaho	345.50
49.	Virginia	311.90
50.	Utah	294.64
51.	Nevada	264.52
U.S. AVERAGE		**$526.52**

[14]*Population data from the U.S. Census Bureau. Expenditure and recipient information from the HCFA 2082 Report.*

Total Medicaid Expenditures Per Recipient

Federal Fiscal Year 1998[15] (Amounts shown are dollars) [Table 7]

1.	New York	7,906.51
2.	New Hampshire	6,448.91
3.	Connecticut	6,350.32
4.	Rhode Island	6,003.74
5.	North Dakota	5,475.52
6.	Minnesota	5,431.61
7.	New Jersey	5,187.60
8.	Massachusetts	5,075.06
9.	Ohio	4,742.08
10.	Illinois	4,526.04
11.	Maryland	4,436.55
12.	Alaska	4,434.13
13.	District of Columbia	4,401.51
14.	Maine	4,382.52
15.	Wisconsin	4,254.57
16.	Indiana	4,222.02
17.	Colorado	4,173.09
18.	Wyoming	4,163.07
19.	Delaware	4,137.90
20.	Iowa	4,092.17
21.	Pennsylvania	3,991.93
22.	South Dakota	3,974.15
23.	Kansas	3,787.51
24.	Kentucky	3,763.16
25.	West Virginia	3,627.86
26.	Alabama	3,609.14
27.	Nevada	3,606.14
28.	Montana	3,585.14
29.	Nebraska	3,566.31
30.	Missouri	3,500.81
31.	Idaho	3,446.39
32.	Oklahoma	3,439.24
33.	North Carolina	3,436.68
34.	South Carolina	3,392.86
35.	Louisiana	3,307.60
36.	Virginia	3,242.63
37.	Arkansas	3,239.25
38.	Arizona	3,238.27
39.	Michigan	3,188.08
40.	Texas	3,071.19
41.	Florida	2,985.86
42.	Mississippi	2,969.27
43.	Utah	2,866.88
44.	Vermont	2,833.58
45.	Hawaii	2,748.62
46.	Oregon	2,694.82
47.	New Mexico	2,617.18
48.	Georgia	2,465.14
49.	California	2,010.20
50.	Tennessee	1,717.88
51.	Washington	1,446.52
U.S. AVERAGE		**$3,501.10**

How does Indiana's Medicaid Program Compare with Other States?

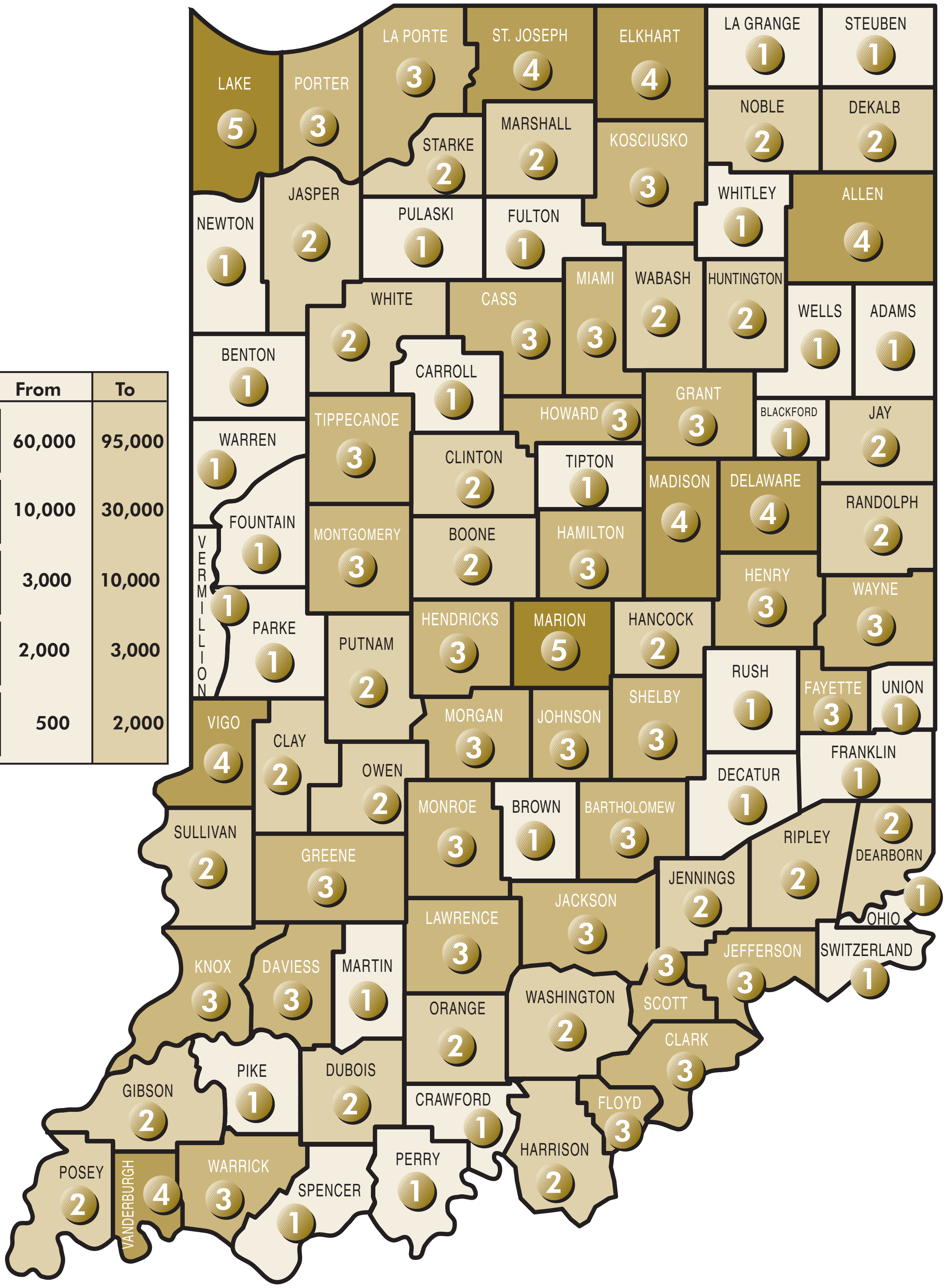
As shown in Table 5 on page 14, Indiana ranks 39th among other states, with 10.3 percent of its state population enrolled in Medicaid. Indiana ranks 34th in expenditures per capita ($435 per capita), while ranking 16th in the total Medicaid expenditures per recipient. As shown in Table 7 on this page, $4,222 was spent per Indiana Medicaid recipient in Federal FY 1999.[16]

[15] Population data from the U.S. Census Bureau. Expenditure and recipient information from the HCFA 2082 Report.

[16] The figure $4,222 is based on the Federal Fiscal Year (October 1-September 30), not the State Fiscal Year (July 1-June 30). The $4,222 in expenditures reported in FFY 1999 is the average of SFYs 1998 and 1999 reported in the "Expenditures per Recipient by Aid Group" table on page 13.

SFY 2000 Average Monthly Enrollment by County [Figure 5]

	From	To
5	60,000	95,000
4	10,000	30,000
3	3,000	10,000
2	2,000	3,000
1	500	2,000



Selected Program Summaries

Hoosier Healthwise Managed Care Program

Hoosier Healthwise is a health insurance program for Hoosier children, pregnant women, and low-income families. The program is offered through the State of Indiana's Family and Social Services Administration and is funded by Medicaid and CHIP. It has been operating since 1994, providing comprehensive health care services to Hoosiers at varying ages and varying income levels. The goals of Hoosier Healthwise are to:

- ✓ Ensure access to primary and preventive care services.
- ✓ Improve access to all necessary health care services.
- ✓ Encourage quality, continuity and appropriateness of medical care.
- ✓ Provide medical coverage in a cost effective manner.

Hoosier Healthwise provides medical benefits designed to meet all of the health care needs of Hoosier Healthwise members, with a special focus on children's health care needs as they grow from infants to young adults. Benefits include primary and preventive care (such as well baby/well child care and regular check-ups), doctor visits, hospital stays, prescription drugs, vision and dental care, mental health care, and other important health care services.

All children, from birth through age 18, are eligible for the Hoosier Healthwise program if their family meets the income guidelines. Adults eligible for the Hoosier Healthwise program include those receiving Temporary Assistance to Needy Families (TANF) and pregnant women with incomes at or just above the established income guidelines.

Families can enroll in Hoosier Healthwise at their local Division of Family and Children (DFC) office or they can go to a conveniently located enrollment center, such as a hospital or community health center. In addition, families can also apply through the mail using the single page (2-sided) application form and mail the completed application form back to the Hoosier Healthwise program. In SFY 2000, Hoosier Healthwise comprised 63 percent of total unduplicated Medicaid enrollees. As of June 2000, there were 376,000 individuals enrolled in Hoosier Healthwise.

PMP Linkage. Hoosier Healthwise is designed to enroll members into the program by linking them with a Primary Medical Provider (PMP). A PMP is a doctor who provides all basic medical services and offers referrals to more specialized care providers. This linkage allows members to have continual access to a doctor who will provide primary and preventive care services, which increases the quality of care to the member while helping to control the cost to Medicaid.

One of the unique features of Hoosier Healthwise is its focus on the relationship between the member and the PMP. Rather than choosing a health plan, members are asked to choose a PMP who is appropriate for their needs. If a member does not choose a PMP, a computerized auto-assignment process is initiated to try to link the member with an appropriate PMP. A PMP is able to determine his or her panel size, a number usually between 150 and 2000, which is the number of Hoosier Healthwise members the

PMP is willing to accept as new and continuing patients. During SFY 2000, Hoosier Healthwise enrolled approximately 70 additional PMPs. There are now PMPs in all 92 Indiana counties.

Delivery Systems and Health Plan Networks. The Hoosier Healthwise program is designed so members choose a primary medical provider (PMP) in one of two delivery systems:

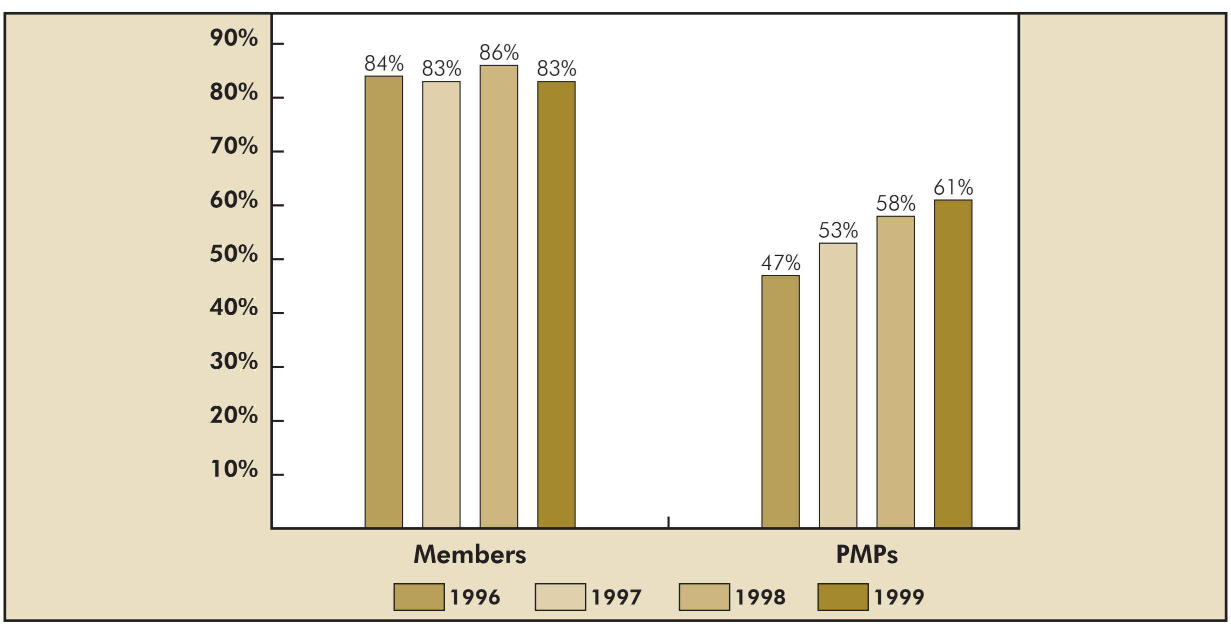
- Primary Care Case Management (PCCM) - This delivery system is referred to as PrimeStep.
- Risk-Based Managed Care (RBMC) - This delivery system is made up of managed care organizations (MCOs). In SFY 2000, the participating MCOs were Managed Health Services (MHS) and MaxiHealth.

Contracted MCOs assume financial risk for developing and managing a health care delivery system that arranges for or provides Hoosier Healthwise covered services. The State pays the MCO a monthly capitation fee per enrolled member. PMPs in the PrimeStep/PCCM delivery system are paid on a fee-for-service basis and are provided with a monthly administrative fee of $3 per member. During SFY 2000, PMP enrollment in the Hoosier Healthwise MCOs declined approximately 25 percent while enrollment in the PrimeStep/PCCM delivery system increased approximately 13 percent.

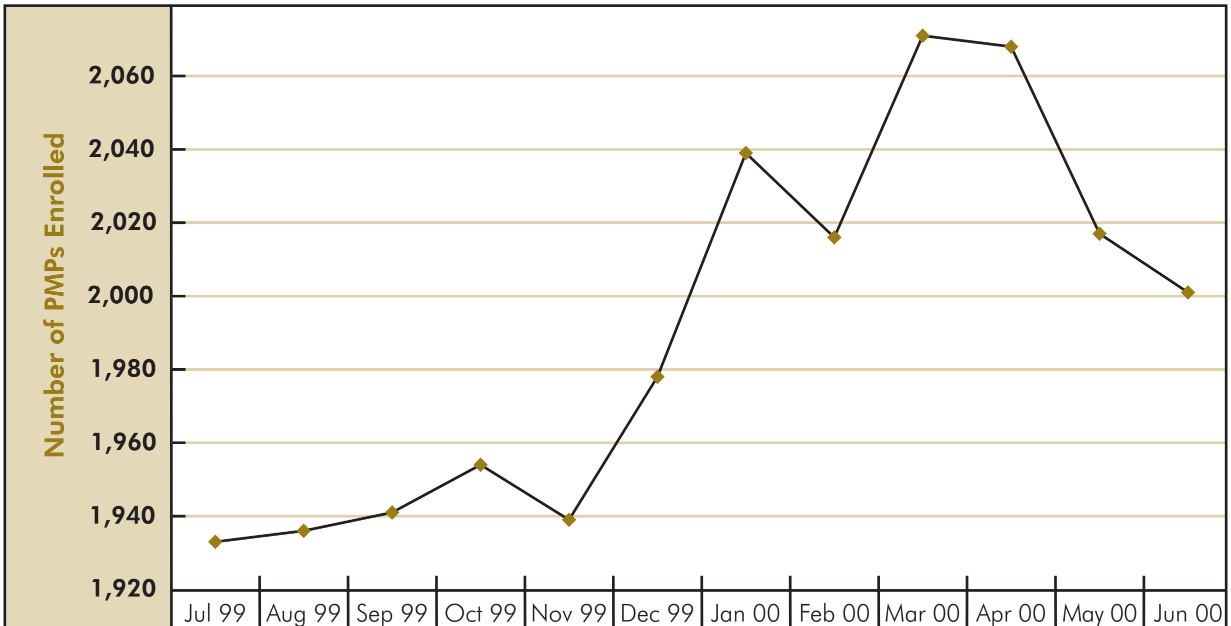
Program Satisfaction. Surveys are conducted annually to assess the attitudes, behaviors and perceptions of enrolled Hoosier Healthwise members and PMPs. Results from a survey of 1,430 Hoosier Healthwise members in SFY 2000, indicated that 81 percent did not have health insurance before enrolling in Hoosier Healthwise. Thirty-three percent of the members surveyed did not have a physician relationship before joining, and 88 percent of the members surveyed stated they had visited their doctor within 6 months of the survey. Also, 82 percent considered their health status "very good" or "good" and 65 percent of the members surveyed considered their health status to be much better than before they enrolled in the Hoosier Healthwise program. Of those members surveyed, a majority (87 to 97 percent) rate physician services such as, physician courtesy, quality of care, appointment lead times, and time spent with the doctor and staff courtesy, as "very good" or "good."

The Hoosier Healthwise PMP survey was completed by 837 participating providers. Since the program was implemented there has been an 160 percent increase in program satisfaction by the PMPs. Satisfaction has increased from 23 percent in SFY 1995 to 61 percent in SFY 2000. A majority (62 percent) of PMPs surveyed are comfortable with their Hoosier Healthwise patient load. The remaining 38 percent of PMPs would prefer to either increase or decrease their Hoosier Healthwise patient loads. The preference for increasing or decreasing panel sizes is split evenly across this group. A majority of PMPs identified problems or concerns with the auto assignment process.

Satisfaction with Hoosier Healthwise Program [Figure 6]

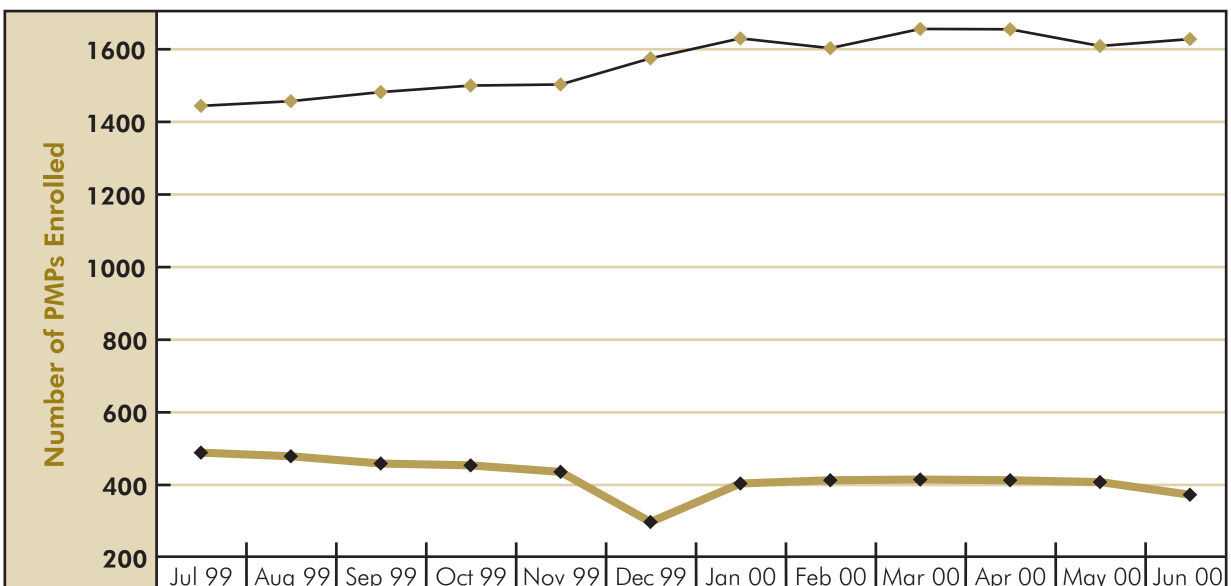


SFY 2000 Hoosier Healthwise Enrolled PMPs [Figure 7]



	Jul 99	Aug 99	Sep 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00	Apr 00	May 00	Jun 00
Enrolled PMPs	1,933	1,936	1,941	1,954	1,939	1,978	2,039	2,016	2,071	2,068	2,017	2,001

SFY 2000 PMP Enrollment by Delivery System [Figure 8]



	Jul 99	Aug 99	Sep 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00	Apr 00	May 00	Jun 00
PCCM	1444	1457	1482	1500	1503	1575	1630	1603	1656	1655	1609	1628
RBMC	489	479	459	454	436	298	404	413	415	413	408	373

Primary Care Case Management (PCCM) — Risk Based Managed Care (RBMC)

Children's Health Insurance Program

In 1997, Congress passed the Children's Health Insurance Program (CHIP) as part of the Balanced Budget Act. The Act allotted money to each State to develop a program to expand health coverage to uninsured children. Indiana chose to implement CHIP through an expansion of the Hoosier Healthwise Program. Thus, in 1998 legislation was enacted (effective July 1, 1998) that increased Medicaid eligibility for all children up to 150 percent of the federal poverty level (about $25,000 for a family of four). This was Phase I of the CHIP implementation. In SFY 2000, approximately 34,000 children received Hoosier Healthwise coverage funded through the CHIP Phase I expansion. In 1999, a non-Medicaid expansion of Hoosier Healthwise was enacted to cover children in families with incomes between 150 and 200 percent of the federal poverty level, effective January 1, 2000. This was Phase II of the CHIP implementation. Through June 30, 2000 approximately 3,300 children were enrolled under this CHIP Phase II expansion.

Long Term Care, Home Health and Hospice Services

In SFY 2000, long-term care services accounted for 41.1 percent[17] ($1.22 billion) of the total Medicaid Program expenditures. Long-term care services include traditional institutional care provided to Medicaid recipients who reside in nursing homes, large and small intermediate care facilities for the mentally retarded (ICFs/MR), as well as non-traditional care provided in community settings through the Medicaid home and community based services waiver program. Other services delivered through Indiana Medicaid's long-term care program include home health care to support the medical needs of individuals who continue to reside in the community and hospice services for persons who are terminally ill.

Despite recent expansions made in the Medicaid waiver programs, Indiana's long-term care service delivery system continues to rely heavily on institutional care for its Medicaid members. Of Medicaid long-term care recipients, 73.5 percent received care in either a nursing home, ICF/MR, or group home in SFY 2000, while only 7.1 percent of recipients received their long-term care services through the Medicaid waiver programs.

OMPP continues to work with other state agencies, consumers and providers to develop a more expansive, yet cost-effective long-term care service continuum that is more responsive to consumer needs. OMPP's long-term care goals are:

- To develop a full continuum of services that are responsive to consumer demand and facilitate the concept of person-centered planning, where services are arranged to meet the individual's needs, rather than fitting individual needs into available services.
- To develop a sound service delivery system that is responsive to market forces and flexible enough to move with changes in consumer service selection. To the extent practicable, low-income citizens should have a full array of options available to them, such that the gap between service availability and quality for low and middle-income (private pay) residents is minimized. Payment for services to the low-income, frail and elderly should be competitive, in order to ensure access to quality care.
- Quality in care and service delivery should become standard, with all long-term care program policies thoughtfully coordinated so that they complement, rather than contradict, each other. Program indicators of quality must be carefully identified, researched, and monitored, so that aggressive quality assurance protocols become a routine and reliable administrative practice.
- With the success of Welfare Reform, Medicaid programs need to be "de-stigmatized", so that they become recognized more generally as health care for those truly in need. The only way to accomplish this paradigm shift is to make consumer and provider education paramount.

As responsible stewards of public funds, OMPP must take proactive steps to maximize the use of existing funds and to explore innovative ways to bring in new funding opportunities. The focus must be on meeting the needs of the whole population in need of services, rather than on developing programs for just a few.

[17]*Long-term care services include services provided through institutional care, community based waiver program, in a home health setting and by hospice service providers.*

Aged. In SFY 2000, Indiana served 55 percent of its aged Medicaid members in nursing homes, 4 percent in the community[18] and less than 1 percent in ICF/MR facilities and group homes.

OMPP reimburse nursing facilities using a case mix reimbursement methodology. This case mix reimbursement system builds upon data collected by Federally required MDS (minimum data set) assessments, and provides a rich source of cost and resident data never before available. OMPP continues to work in collaboration with nursing home provider representatives to develop a comprehensive audit program designed to assure payment integrity, verify service delivery, and ensure provider record-keeping accuracy.

Medicaid Payments for Nursing Facility Patients [Table 8]

	Number of Unduplicated Nursing Facility Patients	Total Annual Nursing Facility Payments	Average Annual Payments Per Nursing Facility Patient	Total Medicaid Patient Days	Average Cost per Medicaid Patient Day	Average Length of Stay
SFY '96	48,390	$679,930,560	$13,904	10,889,381	$62	223 days
SFY '97	48,906	$697,944,997	$14,271	10,621,931	$66	217 days
SFY '98	47,792	$687,662,853	$14,389	11,007,144	$62	230 days
SFY '99	52,526	$761,534,124	$14,498	10,848,121	$70	207 days
SFY '00	50,454	$772,959,757	$15,320	10,736,161	$72	213 days

Developmentally Disabled. In SFY 2000, of Indiana's 23,341 mentally retarded/developmentally disabled Medicaid enrollees[19], 2.2 percent are served in state operated facilities, 4.0 percent receive care in ICFs/MR, and 16.1 percent in group homes. The number of state facility residents declined approximately 50 percent in SFY 2000. This is due to the movement of enrollees from institutions to community settings. Although fewer members are being served in state facilities, the costs for those who remain are still significant.

Progress continues toward serving individuals with mental retardation/developmental disabilities in the least restrictive, most integrated settings possible. State operated facilities continue to be downsized by placement of individuals to less restrictive settings.

SFY 2000 Medicaid Payments for ICF/MR [Table 9]

	Number of Unduplicated Residents	Total Payments	Annual Cost Per Resident
Group Home ICF/MR	4,176	$199,873,533	$47,862
Large Private ICF/MR	1,064	$36,995,193	$34,770
State ICF/MR	523	$52,350,946	$100,097

[18]*Community Services are defined as home health, waiver and hospice categories of service.*

[19]*This number combines members with DSM-IV diagnosis codes including mental retardation, pervasive developmental disorders and tic disorders.*

Home Health Care Services. Other services delivered through Indiana Medicaid's long-term care program include home health care to support the medical needs of individuals who continue to reside in the community. Home health services provided by the Indiana Medicaid Program include skilled services provided by a registered nurse or a licensed practical nurse, home health aide services, and therapy services including physical, speech and occupational therapy. These services require prior authorization by the Office of Medicaid Policy and Planning.

Medicaid Payments for Home Health Care Services [Table 10]

	Number of Unduplicated Home Health Recipients	Total Annual Home Health Payments	Average Cost Per Home Health Resident
SFY 1996	9,640	$41,060,478	$4,259
SFY 1997	11,129	$42,731,454	$3,840
SFY 1998	11,738	$45,695,611	$3,893
SFY 1999	9,438	$46,703,860	$4,948
SFY 2000	10,923	$47,477,204	$4,347

Hospice Services. SFY 1999 marked the first full year of the Medicaid hospice program. In SFY 1999, Medicaid paid $19,506,178 for hospice services provided to 1,131 individuals enrolled in the hospice program. In SFY 2000, Medicaid paid $7,745,526 for hospice services for 1,686 people. These amounts are not representative of all the hospice services provided during SFY 1999 and SFY 2000 as hospice providers may experience a delay in Medicaid reimbursement due to outstanding hospice authorizations and suspended or denied claims that require resolution on the part of the hospice provider. The disparity between the $19,506,178 paid for hospice services in SFY 1999 and the $7,475,526 paid for hospice services in SFY 2000 results from claim submission lag and the claims processing process.

Hospice providers are paid a per diem for hospice-covered services rendered to Medicaid enrollees. These covered services are delivered and reimbursed according to one of the four levels of hospice care: routine home hospice care, continuous home hospice care, inpatient respite hospice care, and general inpatient hospice care. Hospice services require authorization by the Office of Medicaid Policy and Planning.

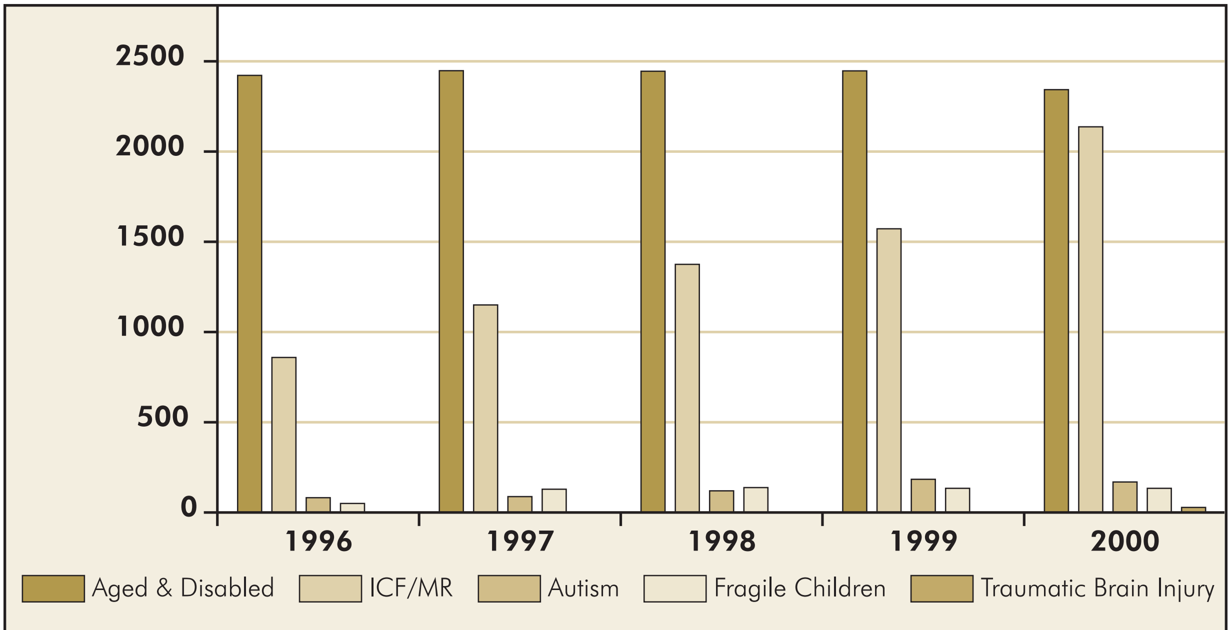
Medicaid Home and Community-Based Services Waiver Program. The goal of the Medicaid home and community-based services waiver program (HCBS) is to establish a framework that will assist states in identifying and serving persons who are in need of institutionalization in the absence of the home and community-based services waiver program and other community supports. It seeks to provide these services through a cost-effective, flexible care plan that allows at-risk persons to remain in the community for as long as possible. Waiver placement options are available on a first-come, first-served basis and are limited to those who meet Medicaid eligibility requirements and are at risk of institutionalization. In essence, an individual must meet minimum nursing facility or ICF/MR level of care criteria to be eligible for the Medicaid home and community-based services waiver program.

Indiana has five federally approved Medicaid home and community-based services (HCBS) waiver programs. These include: Aged and Disabled Waiver; Intermediate Care Facility for the Mentally Retarded (ICF/MR) Waiver; Autism Waiver; the Medically Fragile Children's Waiver; and the new Traumatic Brain Injury Waiver which was implemented on January 1, 2000. A sixth waiver program to provide assisted living services is scheduled for implementation in SFY 2002.

The HCBS Waiver program includes the following services in addition to the services already available (e.g., physician, hospital, home health, etc.) to all Medicaid recipients:

- Case management and assessment
- Respite
- Personal attendant care
- Companion care
- Homemaker
- Home and environmental modifications
- Adaptive aids and devices
- Assistive technology
- Adult day care
- Home-delivered meals
- Residential-based habilitation
- Supported employment
- Pre-vocational services
- Personal emergency response systems
- Family/caregiver training
- Supported living services/Behavior management
- Extended State Plan services of physical therapy, speech therapy and occupational therapy
- Transportation to waiver programs
- Group and/or individual habilitation

Waiver Recipients by Category [Figure 9]



Category	1996	1997	1998	1999	2000
Aged & Disabled	2,422	2,448	2,445	2,447	2,343
ICF/MR	859	1,150	1,375	1,572	2,137
Autism	82	88	120	184	169
Fragile Children	50	129	138	134	134
Traumatic Brain Injury	-	-	-	-	28
Total	**3,413**	**3,815**	**4,078**	**4,337**	**4,811**

Indiana Long Term Care Insurance Program

The Indiana Long Term Care Insurance Program, also known as the Indiana "Partnership Program," is a program administered by OMPP that encourages the sale and purchase of private long term care insurance by providing "Medicaid asset protection" to purchasers of qualifying policies. The program is a partnership among OMPP, the Indiana Department of Insurance and private long-term care insurance companies. Indiana is one of only four states (along with California, Connecticut and New York) with such a program. The program was designed to:

- ✓ Provide incentives for the purchase of private long term care insurance;
- ✓ Allow Hoosiers to plan for their long term care needs without fear of impoverishment;
- ✓ Contain the growth of Medicaid expenditures for long term care by encouraging the purchase of private insurance;
- ✓ Improve the quality and affordability of long term care insurance policies while making them more affordable, and
- ✓ Increase public awareness of the costs, risks, and options relating to long-term care.

The Indiana General Assembly passed the legislation that created the Partnership Program in 1987. Federal approval was received in December 1991 and the availability of the first Partnership policies was announced on May 17, 1993. Through June 2000, 11,480 Partnership policies have been purchased.

In March 1998, the authorizing statute was amended thereby expanding the asset protection feature by adding the option of unlimited asset protection. For a person to earn unlimited asset protection, he or she would first need to purchase a Partnership policy with a minimum initial coverage in the amount specified by the State. (This was $154,350 in calendar year 2000.) The State-set dollar amount increases each year and applies only to new policies purchased during that year. The policyholder would then need to exhaust the benefits of the policy. The amount of benefits exhausted must equal, at a minimum, the state-required minimum coverage amount specified for the year that the policy was purchased as inflated from the year of purchase at a 5 percent annual compounded rate. People who purchase Partnership policies that do not meet the criteria for unlimited asset protection will receive dollar-for-dollar asset protection. Dollar-for-dollar asset protection means that for every dollar of benefits paid out by the policy an equal dollar amount of asset protection is earned.

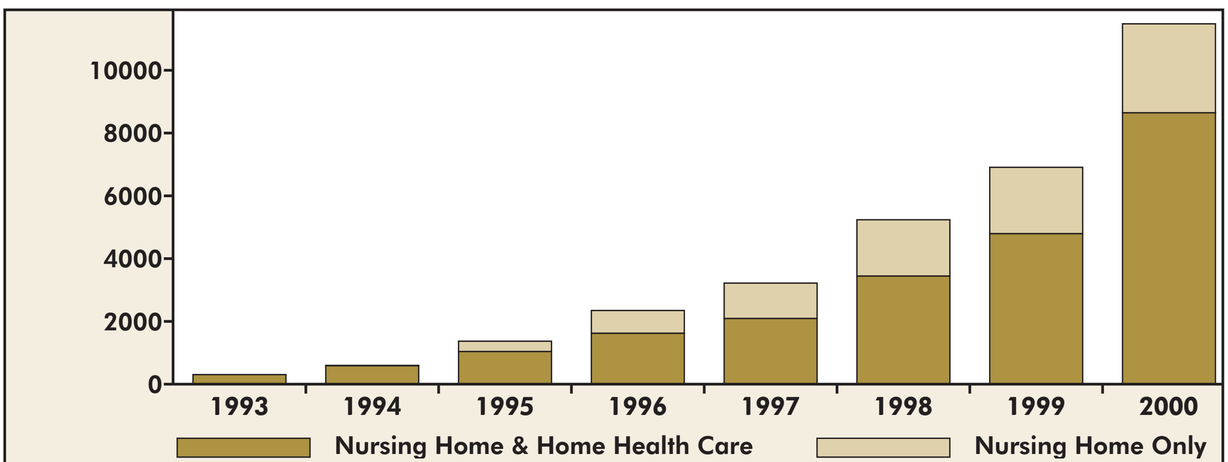
All Partnership policies contain the consumer protections of standardized criteria for when the benefits will begin to be paid, as well as an inflation protection feature.

Through June 30, 2000, fifty policyholders have received policy benefits since the inception of the Partnership Program. Of these fifty, fourteen were receiving policy benefits as of June 30, 2000, nine have died and approximately 73 percent have used the policy benefits for nursing home care.

Purchaser Information based on 11,480 policies purchased through June 30, 2000 [Table 11]

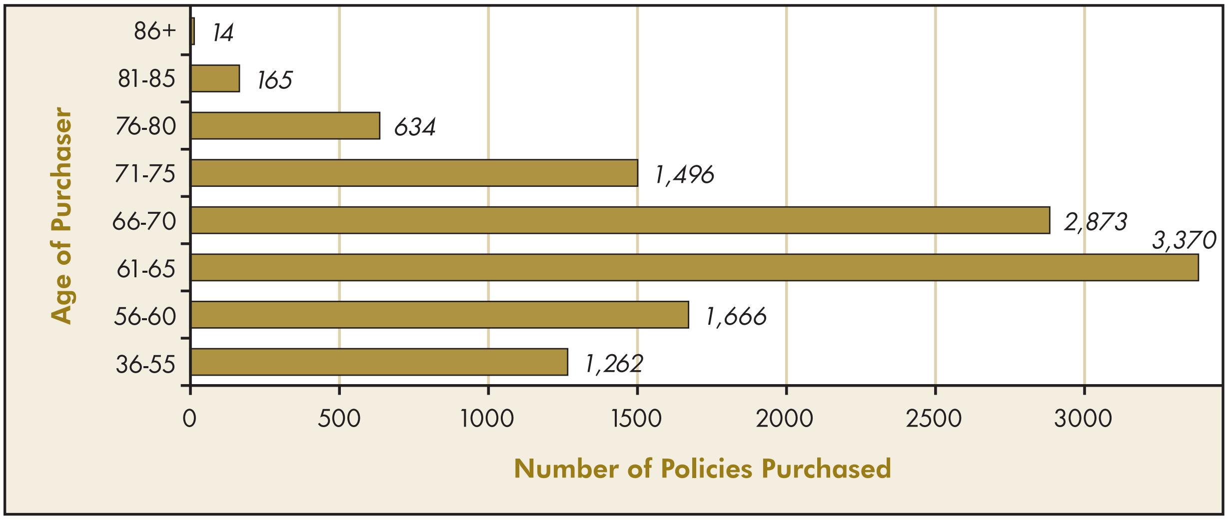
Female	59%
Married	74%
First-time purchasers	89%
Average age at purchase	65 years

Cumulative Number of Partnership Policies Purchased [Figure 10]



Type of Policy	1993	1994	1995	1996	1997	1998	1999	2000
Nursing Home Only	0	12	329	728	1,127	1,794	2,116	2,834
Nursing Home & Home Health Care	305	586	1,040	1,620	2,093	3,444	4,793	8,646
Total	**305**	**598**	**1,369**	**2,348**	**3,220**	**5,238**	**6,909**	**11,480**

Age Distribution of Partnership Policy Purchasers [Figure 11]



Third Party Liability

As a condition of eligibility for the Medicaid Program, every Medicaid enrollee must legally assign their rights to any third party payment for medical expenses from any available resource to the Medicaid Program. Under federal and state law, OMPP is responsible for ensuring that Indiana Medicaid pays medical services only when there is no other source (third party) to pay for the member's healthcare. Third party resources include any entities, individuals, or programs that are legally responsible for paying the medical expenses of Medicaid enrollees.

Cost Avoidance, Post Payment Recovery and Casualty Collections. Third party liability (TPL) recovery efforts occur both before and after payment of claims. IndianaAIM, the Medicaid claims processing system, maintains a record of insurance coverage per member. Through the use of system edits, if TPL resources are identified during claims processing, the claim will not pay unless the third party resource has been billed and the claim is submitted with evidence of third party payment or denial (referred to as "cost avoidance"). Post payment recovery activities (referred to as "pay and chase") center on invoicing health insurance companies for services that were initially paid by Medicaid. Post payment recovery is necessary when (a) federal law prevents the use of cost avoidance for certain services, or (b) the presence of health insurance coverage is detected after a claim for service is paid. In addition to the cost avoidance and post payment recovery, TPL recoveries also result from legal settlements of casualty cases. Each month a number of Medicaid members receive medical care as a result of injuries or accidents. Medicaid is responsible for pursuing recovery from liable third parties. These resources are also identified through IndianaAIM claims processing edits and through referrals from outside entities such as insurance companies, providers, attorneys, and Medicaid members.

The TPL policies established by the state have saved Indiana taxpayers millions of dollars through cost avoidance, post payment recovery and casualty collection activities. TPL related savings for State Fiscal Years 1998 through 2000 are as follows:

State Fiscal Years 1998 – 2000
TPL Savings ($ are in millions) [Table 12]

	SFY 1998	SFY 1999	SFY 2000
Post Payment Health Recoveries	$6.1	$14.8	$11.4
Casualty Collections	$1.9	$1.5	$1.0
Cost Avoidance Total	$414.2	$399.6	$465.8
Health Cost Avoidance	*$43.5*	*$45.1*	*$51.9*
Medicare Cost Avoidance	*$370.7*	*$354.5*	*$413.6*
Total Savings	**$422.2**	**$415.9**	**$477.9**

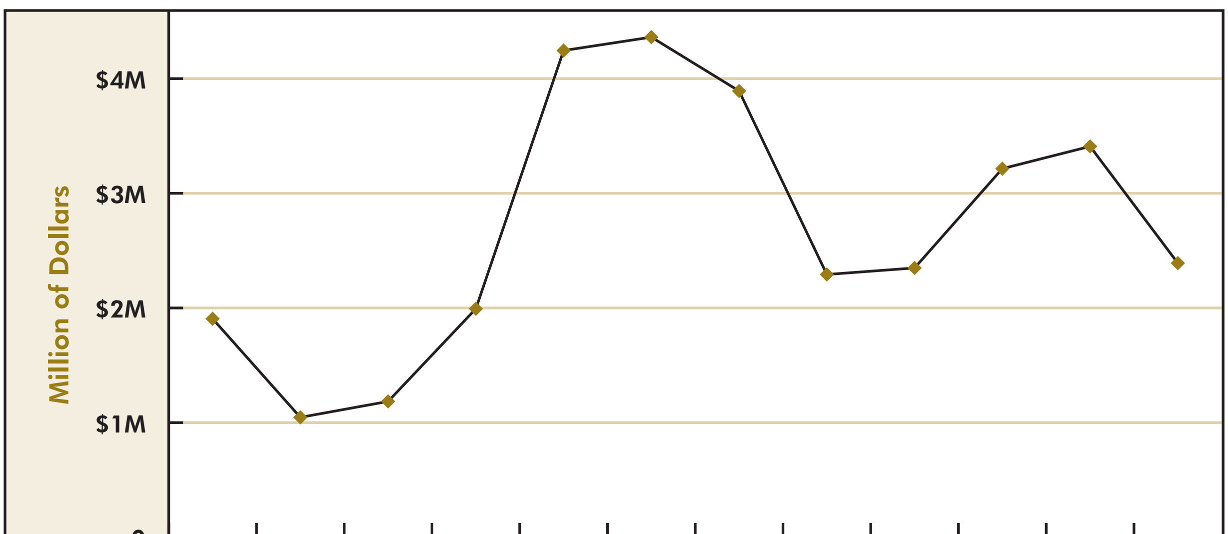
In SFY 1999, a special project was implemented by Indiana Medicaid that resulted in the recovery of $9.2 million. This amount was in addition to the regular TPL recovery effort of $5.6 million and resulted in a combined total of $14.8 million. SFY 2000 TPL recoveries totaled $11.4 million. No special projects were implemented in SFY 2000, which explains the overall decline in health recoveries of 3.4 million (23%) from SFY 1999 to SFY 2000, as illustrated in Figure 12.

With regards to cost avoidance, the overall increase in SFY 2000 was $65.9 million(16.5%). The Medicare cost avoidance portion increased $59.1 million (16.5%), from $354.5 million to $413.6 million in SFY 2000. The health cost avoidance portion increased by $6.8 million (15.1%), from $45.1 million to $51.9 million during this time.

Increased data matching efforts have contributed to the increase in cost avoidance for SFY 2000. Of particular importance has been an effort to improve the data match with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which provides health care coverage through private insurers to civilian dependants of active members of the uniformed services. In addition, the Medicare Part B processing problems evidenced in SFY 1999 were resolved in SFY 2000, which resulted in an increase in Medicare B cost avoidance by $7.6 million (7%) increase from SFY 1999. Similarly, Medicare Part A cost avoidance increased by $51.5 million (21%) from SFY 1999.

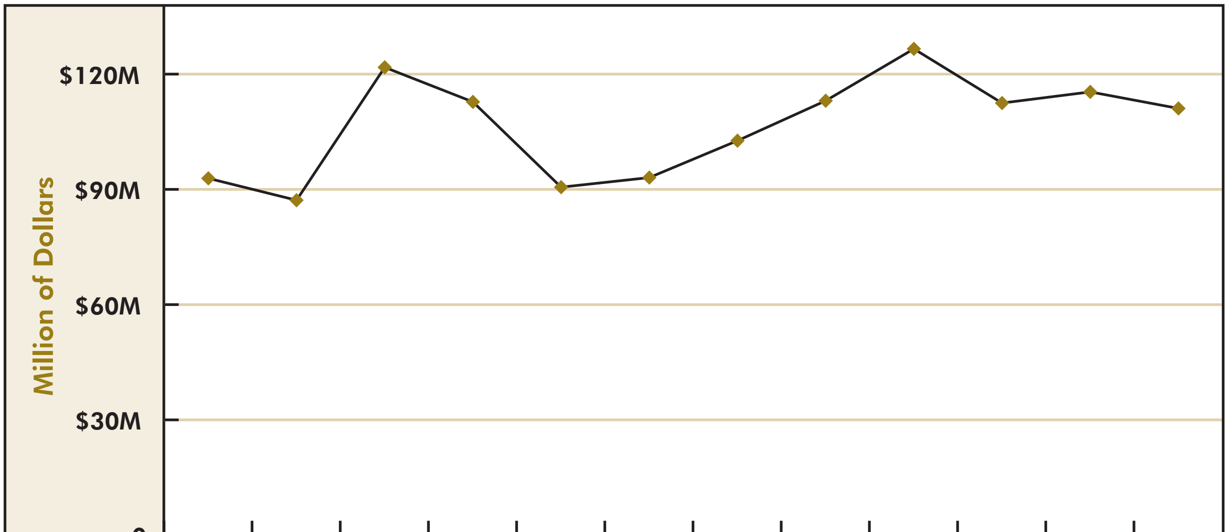
Federal law requires that state Medicaid agencies pay the Medicare premiums for members that are enrolled in both Medicaid and Medicare. The federal government pays one-half of the Medicare premium expense. During SFY 2000, the state share of the Medicare premiums paid on behalf of Medicaid members totaled $32.5 million. Medicare cost avoided dollars for SFY 2000 totaled $413.6 million for a net savings to Medicaid (after Medicare premium payments) of $381.1 million for SFY 2000.

Post Payment Health Recoveries for State Fiscal Years 1998 – 2000 [Figure 12]



1Q98	2Q98	3Q98	4Q98	1Q99	2Q99	3Q99	4Q99	1Q00	2Q00	3Q00	4Q00
$1.906	$1.046	$1.185	$1.993	$4.425	$4.362	$3.892	$2.292	$2.349	$3.215	$3.409	$2.391

Cost Avoidance for State Fiscal Years 1998 – 2000 [Figure 13]



1Q98	2Q98	3Q98	4Q98	1Q99	2Q99	3Q99	4Q99	1Q00	2Q00	3Q00	4Q00
$92.9	$87.2	$121.8	$112.8	$90.6	$93.1	$102.7	$113.1	$126.6	$112.5	$115.4	$111.1

Estate Recovery

Indiana's Medicaid Program recovers the costs of medical care from the estates of Medicaid members who received services after the age of 55 years. According to the Family and Social Service Administration, the state recovered just under $4.15 million from beneficiaries' estates in SFY 2000.

Drug Rebate

The federal Omnibus Budget Reconciliation Act of 1990 (OBRA 90) established a requirement that, for drug manufacturers' products to be covered by State Medicaid programs, the individual manufacturers had to enter into rebate agreements with the federal government, acting on behalf of the individual states. Under this system, each state receives back from each rebating manufacturer a portion of the Medicaid funds expended by the state for the manufacturer's drug products.

Since the inception of the drug rebate program, Indiana Medicaid has recaptured approximately $406.5 million in rebates. During SFY 2000, Indiana Medicaid realized $70.5 million in drug rebate proceeds. This represents a 15.6 percent increase over SFY 1999 proceeds of approximately $61 million in drug rebates. Increased drug rebate collections for SFY 2000 resulted from increased utilization and costs of drugs and heightened efforts to resolve outstanding disputes with manufacturers relative to the amounts identified as being owed to Medicaid.

Program Integrity

OMPP is responsible for monitoring both provider and member utilization of Medicaid services to ensure that the services rendered are necessary and in the optimum quality and quantity. Federal law also requires OMPP to have the ability to identify and refer cases of suspected fraud or abuse in the Medicaid program for investigation and/or prosecution, if warranted. Utilization review safeguards against unnecessary care and services and ensures that payments are appropriate according to the policies established by Indiana Medicaid relative to coverage, reimbursement and billing.

Organization and Goals. Currently, Indiana Medicaid has a variety of avenues for investigation of fraud and abuse. Within the fee-for-service and the PrimeStep/Primary Care Case Management (PCCM) Program, the Surveillance and Utilization Review (SUR) Unit conducts fraud and abuse prevention activities. Review of providers who provide services in the Hoosier Healthwise MCOs is performed internally by the MCOs. The MCOs also attend the monthly SUR meeting to discuss preventive and responsive strategies relative to Medicaid fraud and abuse. OMPP staff working in the Hoosier Healthwise Program addresses review of the MCOs internal processes. Major objectives of this area include:

- ✓ Development of statistical profiles of health care delivery and utilization patterns by providers and members in various categories of service
- ✓ Monitoring Utilization
- ✓ Identification of abusive or suspected fraudulent practices of providers and members
- ✓ Investigation and correction of inappropriate utilization of the Medicaid Program by individual providers and members
- ✓ Identification of utilization trends and patterns to develop recommendations for program changes
- ✓ Identification of concerns in the level or quality of services provided to Medicaid members
- ✓ Education and possible sanctions of members and providers found to have abused or inappropriately utilized services under Indiana Medicaid

Referrals. The SUR Unit investigates reports of possible fraud and abuse for both providers and members that are received from a variety of sources, including state staff, other providers, officials, members, the public or county Division of Family and Children (DFC) Offices. OMPP maintains a toll-free telephone line for reporting instances of possible fraud and abuse for investigation.

Utilization Review. With the assistance of a computerized SUR reporting system individual provider and member statistical profiles are generated. These profiles are used to identify cases requiring further review, which may include desk or field audits of provider medical records, claims and billing practices. Depending upon the audit findings, the SUR Unit may take one or more of the following actions:

- ✓ Close the case because no aberrant practice was found
- ✓ Provide appropriate education to correct minor infractions
- ✓ Request repayment of improper reimbursements
- ✓ Require manual pre-payment review of a provider's claims because of serious billing errors which show a consistent lack of knowledge of Medicaid rules, or a lack of desire to abide by these rules
- ✓ Make a referral to the Indiana Medicaid Fraud Control Unit
- ✓ Place a Medicaid member on a "restricted card program" in which payments for that member's care are limited to one primary physician, one pharmacy and one hospital, except for emergency or referral services

In SFY 2000, the manual pre-payment review process avoided $1,430,836 in payments. In addition, $865,475 in payments were avoided by placing Medicaid members on restricted card access.

The utilization review process also assists OMPP in making important policy decisions. For example, the utilization review activities may identify areas of policy that require clarification or change. It is therefore a valuable tool in shaping policy guidelines to ensure services are provided in an efficient and effective manner.

State Fiscal Years 1998 – 2000
Utilization Review Statistics [Table 13]

	SFY 1998	SFY 1999	SFY 2000
On-Site Audits	75	30	142
Dollars Recovered	$1,345,014	$4,346,519	$1,015,382
Members on Restricted Card Status	130	186	268

During the first six months of SFY 1999, the SUR Unit, in conjunction with FSSA legal staff, concentrated on closure of existing appeal cases. As a result, the number of on-site audits was less than usual and the amount of dollars recovered was greater. In SFY 2000, dollars recovered reflect a return to the normal audit cycle.

Fraud Control. The Indiana Medicaid Fraud Control Unit (IMFCU) of the Indiana Attorney General's Office investigates allegations of Medicaid fraud and abuse. During SFY 2000, IMFCU generated $1,521,007 in judgments ordered from fraudulent Medicaid billings. This amount includes restitution to the Medicaid program and funds returned to Medicaid members in cases involving the theft of patient personal funds.

Medicaid fraud takes many forms. In many cases, it occurs when medical providers double bill for services, provide services that are not medically necessary, bill for services which are not provided or miscode the diagnosis or procedure code in order to receive a higher level of reimbursement. The IMFCU has established a hotline to encourage people to report instances of fraud. Many investigative leads come through the hotline, mostly by employees, ex-employees or competitors of the provider in question. Other sources of information include federal Medicare investigators, medical licensing boards, county offices, the SUR Unit, MCOs and other agencies in the health care fraud task forces. All referrals and leads are investigated by the IMFCU. Possible remedies include:

- Referring the case to county or federal prosecutors for criminal prosecution
- Initiating a civil suit in state court or referring it to a civil United States Attorney to recover restitution, treble damages, fines and/or costs
- Referring to an administrative agency to either take action against the provider's professional license or suspend participation in the Indiana Medicaid Program.

Often, the IMFCU pursues parallel criminal and civil cases and, upon completion of the criminal case, refers the provider for administrative action.

Medicaid fraud recovery has benefited from greater interagency cooperation. Monthly meetings of the OMPP, IMFCU, the SUR unit, and representatives of Medicaid MCOs are held to coordinate activities and share information. The IMFCU is also a member of two health care fraud task forces, each of which includes representatives from the United States Attorney's Office, the Federal Bureau of Investigation, the Internal Revenue Service, postal inspectors, the Department of Health and Human Services, Office of Inspector General, Medicare and Medicaid fiscal intermediaries and managed care organizations.

SFY 2000 Medicaid Fraud Control Unit Statistics [Table 14]

8 convictions: ***7 for fraud*** ***1 for theft***	**$1,521,007 for Judgments Ordered** **273 cases pending**

Drug Utilization Review

An important component of the Indiana Medicaid pharmacy benefit from both a cost and quality of care perspective is drug utilization review (DUR). DUR is comprised of two separate and distinct, yet complimentary, components: prospective DUR (pro-DUR) and retrospective DUR (retro-DUR). Under Indiana Medicaid's point-of-sale claims submission process, each time a pharmacy provider submits an electronic claim, the pro-DUR system checks the paid claims history to see if the newly prescribed drug will in some fashion negatively interact with a medication that the patient may already be taking. The pro-DUR system alerts the pharmacist to any such possibilities, so that the pharmacist can initiate necessary action (e.g., contact the prescriber, discuss the matter with the patient, not dispense the drug, etc.).

Complementing the pro-DUR system is the retro-DUR functionality. This feature allows for analysis and review by the State's Medicaid Drug Utilization Review Board of patterns of prescribing and dispensing. In retro-DUR, paid pharmacy claims are periodically subjected to software that creates reports depicting how selected drug classes are being utilized. The Board subsequently reviews these aggregate level reports and determines whether or not educational interventions by the Board are warranted. The software also has the capability of generating intervention letters that, upon approval by the Board, can be sent to specific practitioners. These letters typically advise the practitioner of a detected prescribing pattern on the part of the practitioner that is not necessarily reflective of commonly accepted practice, suggests possible alternatives, and allows for a response should the prescriber choose to issue one.

Both pro-DUR and retro-DUR processes are educational in nature, and neither results in the denial of Medicaid claims nor attempts to dictate practice modes. They are designed to improve the quality of care afforded Medicaid members by virtue of providing information and to ensure that program funds are expended for services provided in accordance with commonly accepted standards of practice.

Prior Authorization

Organization and Purpose. The primary objective of prior authorization (PA) is to serve as a utilization management measure to allow payment only for those services that are medically necessary and covered by the Medicaid program. Although the PA process certifies the medical necessity of services prior to Medicaid reimbursement, only covered services, which are those set out in the Medicaid medical policy regulations, may be reimbursed.

Duties. PA staff review requests for authorizations in all categories of service in the Medicaid program. Requests are submitted via paper, telephone or fax transmission modes. Decisions must be entered into the IndianaAIM system within ten days of the request and receipt of all appropriate medical documentation. Information entered into IndianaAIM, which includes category of service, units requested, approved, denied or modified, as well as dates received and entered, allow PA staff to measure trends in decision-making as well as in the type of services requested. On average, approximately 20,000 PA transactions are processed each month with the highest number of requests being in the areas of Durable Medical Equipment, Transportation, Home Health and Mental Health categories of service.

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